Commonwealth of Massachusetts
Rate Setting Commission

Understanding the Commission

Fiscal Year 1993 Annual Report
Narrative Updated through May 1994

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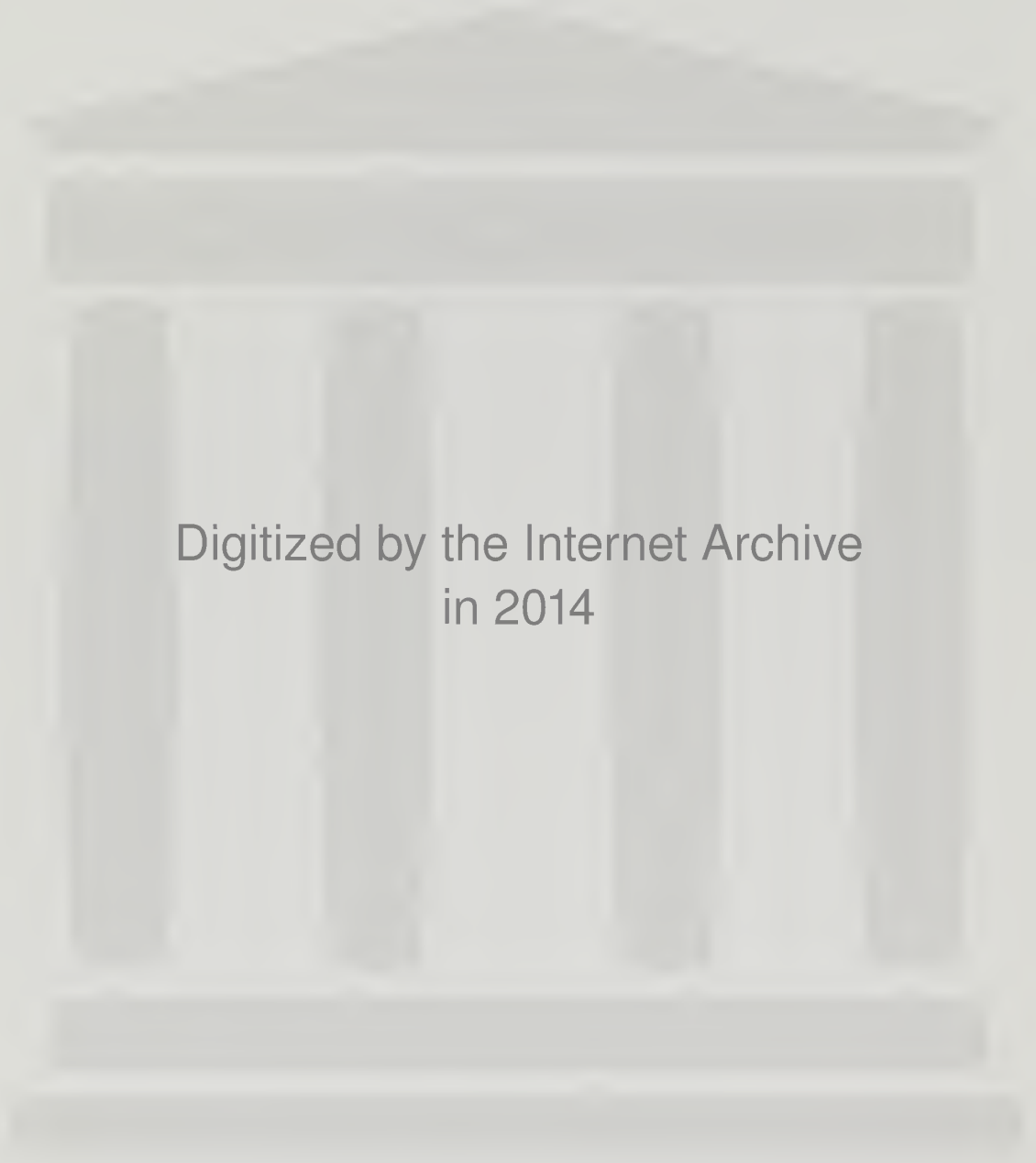

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Mission Statement

The agency mission of the Massachusetts Rate Setting Commission is to promote for the citizens of the Commonwealth of Massachusetts cost-effective systems for delivering high quality, accessible health services. We accomplish this mission by collecting, analyzing, employing and disseminating health care information for the development of public policy and for use by payers, providers and other participants of the health care delivery system. In developing public policy, the Commission designs, implements, monitors and evaluates financing and pricing mechanisms. The Commission focuses public debate through extensive public hearings and uses the regulatory process responsibly and judiciously. In fulfilling the mandate of our health information role, the Commission: 1) encourages the efficient operation of the health care marketplace, 2) provides information which serves as a critical management tool for health care providers, 3) disseminates useful purchasing information to payers, insurers and employers, and 4) the agency studies this information to evaluate the effectiveness of the Commonwealth's health care financing policies.

Understanding the Commission

The Massachusetts Rate Setting Commission (MRSC) is an administrative agency within the Executive Office of Health and Human Services (EOHHS). See Appendix 1: MRSC in the Executive Branch. The agency is responsible for: (1) establishing rates of payment for health care services purchased by the Commonwealth of Massachusetts, (2) oversight of the acute care hospital payment system, (3) non-acute care hospital charge regulation, (4) workers compensation rates, and (5) the analysis and publication of health cost and utilization information for use by lawmakers, state officials, providers, insurers, consumers and other interested parties in the formulation of public policy and the purchase of health care services.

Financing and Pricing Mechanisms

Working with state and federal agencies, provider groups, payers, client advocacy groups and other interested parties, the Commission develops, implements, monitors and evaluates the financing and pricing mechanisms for a wide variety of health care services. These services include those provided by non-acute care facilities (chronic hospitals and public institutions), long-term care facilities (nursing homes and rest homes) and thirty-three (33) classes of ambulatory care provider types—such as physicians, pharmacists, dentists, physical therapists, mental health providers, community health centers, home health agencies and many other provider groups.

Proposed rates for these services are subject to the public hearing process and are promulgated through the official Code of Massachusetts Regulations (CMR) filed with the Office of the Secretary of State. As required by statute, long term care and chronic hospital regulations are reviewed on an annual basis while ambulatory care regulations are reviewed on a biennial basis. See Appendix 2: Public Hearing Process for an overview of these rules. The permanent records of the Commission also are subject to the rules of public disclosure and are available to anyone.

Chapter 495: The Hospital Financing Law

Under Chapter 495 of the Acts of 1991, Massachusetts' acute care hospital financing law, the Commission is directed to implement and evaluate the competitive, marketplace-based system. In meeting this responsibility, the Commission sets certain types of Medicaid rates, determines payment amounts from the Uncompensated Care Pool to hospitals delivering free care, studies the cost of health insurance, and carries out other provisions of the law.

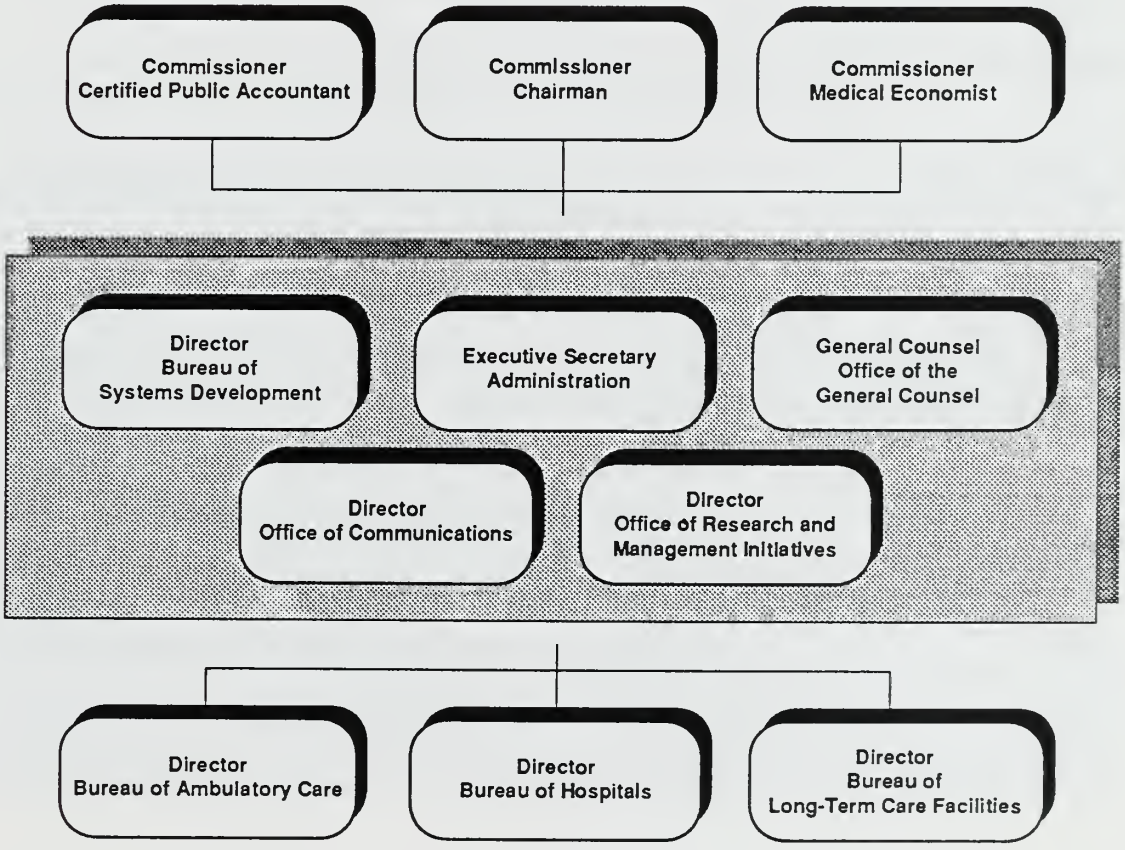
In addition, the MRSC analyzes and provides hospital-specific data on charges, costs, volume and other areas of interest. The dissemination of this information to payers, employers and insurers better enables consumers to make informed decisions regarding choice of provider. This information also serves as a management tool for providers. Collectively, these activities help to ensure that the hospital financing system is operating as intended—in an efficient and cost-effective manner, thereby reducing the cost of health care and promoting a healthy economic environment.

Health Care Information

The Commission's information mandate includes the collection, analysis and distribution of data and information on all types of health care, including hospitals, long-term care facilities, and ambulatory care and community-based services. The information analyzed by the Commission is being organized, published and disseminated to a broad array of public and private sector organizations, businesses and policy makers.

The purpose of this activity is: 1) to encourage the efficient operation of the health care marketplace, 2) to disseminate useful information to payers, insurers and employers, 3) to provide information that can serve as a critical management tool for health care providers, and 4) to evaluate the effectiveness of the Commonwealth's health care financing policies, including the implementation of Massachusetts' acute care hospital financing law (Chapter 495).

Organization Chart



The Massachusetts Rate Setting Commission serves an important role with respect to health care services purchased by the Commonwealth of Massachusetts on behalf of publicly-aided patients, including most Medicaid-covered services. In certain instances, the Commission also sets rates for some other purchasers, including charge-payers and insurers. In meeting these statutory responsibilities, the Commission performs a number of essential functions.

Purpose of Rate-Setting & Oversight Functions

The Commission:

1) *performs financial analysis crucial to setting public policy;*

2) *develops and implements rate-setting mechanisms for health care; and*

3) *collects, analyzes and disseminates information useful to payers, providers, employers and other interested parties.*

The Commission develops and implements rate-setting methodologies through regulations pertaining to a diverse array of institutional and noninstitutional services.

Regulations

The agency's regulations govern or otherwise concern:

1) *Medicaid rates, including rates for ambulatory care services, nursing homes, disproportionate share hospitals, hospital emergency services and the non-acute hospital payment system;*

2) *rates of payment for workers compensation;*

3) *payments to hospitals from the Uncompensated Care Pool for free care;*

4) *the non-acute hospital charge-payer system.; and*

5) *hospital compliance settlements as determined by Chapters 23 and 495.*

The Commission's oversight and rate-setting activities incorporate a statutory public hearing process, an annual or biennial review of each regulation, rules of public disclosure, and the maintenance and ready-availability of the Commission's public records. These rules and procedures ensure a fair and open process on matters of public policy and health care financing.

Outcome

The rate-setting work of the Commission ensures:

1) better access to quality health care services;

2) adequate rates of reimbursement for providers; and

3) reasonable rates in terms of taxpayer expense and the cost to payers.

The health care information disseminated by the Commission:

1) promotes the efficient operation of the health care marketplace;

2) gives payers, insurers, and employers the information with which to make better purchasing decisions;

3) gives providers useful management and budgeting tools; and

4) provides the Commonwealth with the information it needs to effectively evaluate and implement its health care policies.

The public process, rate methodologies, and health care information initiatives work together to promote efficient, competitive operations among health care providers, thereby reducing health care costs to employers and promoting economic growth in the Commonwealth.

Introduction

The Massachusetts Rate Setting Commission is responsible for the implementation and evaluation of Chapter 495 of the Acts of 1991 (Chapter 495), the acute care hospital financing law. This law controls health care costs through a more simple, less regulated reimbursement system. It streamlines the rules of payment and allows the marketplace to play a significant and much larger role in the allocation of resources.

Chapter 495 requires implementing and overseeing many changes to the hospital financing system—changes for which the Commission is responsible. In addition to implementing these provisions, the Commission also analyzes and provides hospital-specific data on charges, costs, volume and other areas of interest to better enable consumers and payers to make informed purchasing decisions. The Commission also monitors and evaluates the Chapter 495 system, publishes related reports, and studies the cost of health insurance.

Rate-Setting Features

Aggregate Revenue Caps

Chapter 495 originally contained a limit on maximum "list prices." Based on these list prices, this mechanism established, for two years, aggregate caps on hospital in-patient revenues. The Commission set price caps, established revenue limitations and monitored acute hospitals for compliance with the revenue provisions of Chapter 495. Price caps remained effective until September 30, 1993. Acute hospital prices were completely deregulated beginning October 1, 1993.

Setting Certain Types of Rates for the Massachusetts Medicaid Program

With regard to Medicaid, the Commission has two specific tasks: 1) to set Medicaid rates for "disproportionate share hospitals" (that is, hospitals which serve a disproportionate number of low income, free care and publicly-aided patients), and 2) to set Medicaid rates for emergency services rendered at hospitals which do not have contracts with the Medicaid program.

Determining Uncompensated Care Pool Payments

The Commission also determines rates of payment from the Uncompensated Care Pool to acute hospitals for free care.

Other Rate-Setting Responsibilities

The Commission sets hospital in-patient and out-patient workers compensation rates, and determined and enforced compliance with acute hospital in-patient revenue caps for the years during which Chapter 23 was in effect (see "Chapter 23: Wrap-Up" on page 10).

Rate-Setting Features of Chapter 495

The Commission is charged with the responsibility to:

1) set price caps, establish aggregate revenue limitations, and monitor acute hospitals for compliance with the revenue provisions of Chapter 495 until September 30, 1993;

2) set Medicaid rates for disproportionate share hospitals and Medicaid rates for emergency services rendered at hospitals without Medicaid contracts;

3) determine Uncompensated Care Pool payments to hospitals;

4) set workers compensation rates; and

5) wrap-up compliance issues under Chapter 23.

Policy Analyses and Data Dissemination

Chapter 495 directed the Commission to continue to collect data from acute care hospitals and to disseminate such information in order to effect various provisions and purposes of the law. In addition, the Commission participates in multi-agency research efforts and helps with the production of reports on study results.

Collecting Data

The Commission is authorized to collect such data as charge books, cost reports, audited financial statements, merged billing and discharge data, the comprehensive financial data of hospitals' affiliated organizations and the salaries and benefits of their top five officers. Additional information may be required from hospitals, if it is determined that the information is necessary to fulfill the reporting mandates and intentions of the law. Such determination may be made by the Commission or by HospPAC. These varied and numerous data resources are used to form the analysis tools from which reports are prepared and published, as detailed below.

Monitoring the Competitive Marketplace—Hospital Costs and Revenues, Financial Condition, Services Provision and Industry Structure

The competitive environment established by Chapter 495 is intended to constrain cost increases in the acute hospital industry, while maintaining access to quality care. As information becomes available, the Commission keeps consumers, providers, legislators and policy makers informed of the effects of the new legislation. Specifically, the Commission is monitoring hospital costs and revenues, financial condition, services provision and industry structure. Through this monitoring role, the Commission is in a position to provide recommendations to policy makers and legislators regarding modifications to the system, as necessary.

Informing the Competitive Marketplace On Hospital Costs and Services

In order for a competitive system to succeed, purchasers must be able to make informed decisions. The Commission produces reports that present comparative hospital cost and service information, including both inpatient and outpatient mental health data. The specific information incorporated into the various publications is determined through discussions with different purchaser groups—insurers, HMOs, business representatives, etc. By providing standardized, comparative information to providers, the Commission can enhance management decisions of hospital administrators. Further, the goal of disseminating information to health care purchasers is to facilitate demanding, yet reasonable, contractual arrangements between purchasers and providers. Ultimately, it is hoped that this will further the cost control objectives of Chapter 495.

Studying the Costs of—and Access to—Health Insurance

The lack of health insurance coverage among, and the cost of health insurance to the citizens of Massachusetts, are major concerns for the Commonwealth. The Commission, in conjunction with the Division of Insurance and the Department of Medical Security, monitors changes in insurance premiums and changes in the availability of health plans offered in the state. Particular attention is paid to changes in the small group market. This information is published and provided to the administration and state legislators to assist them in making health policy decisions.

Monitoring Services for the Uninsured

The Commission monitors changes in patterns of use and the availability of services for the uninsured to ensure that access to care is maintained under Chapter 495. The Commission determines whether the care received by uninsured patients is different from care received by insured patients, whether there is a difference in the availability of health care services in areas with a higher proportion of uninsured, and if there have been shifts in the sites of care for the uninsured.

Quality Measures

Health care quality is a crucial component affecting the health care market. Many parties are interested in looking at and measuring quality. Since there is no consensus on how to accomplish this and only limited frameworks available, the Commission has completed *Health Care Quality and the Importance of Outcomes Measurement*, a background paper on this important subject. In order to accomplish this task, Commission staff conducted an extensive review of existing literature on this subject and looked at the experience of other states pursuing meaningful quality measures.

Studying Quality Improvement

Chapter 495 established an advisory commission to study quality improvement principles in the health care industry; the Chairman of the Rate Setting Commission is one of the members of this group. The advisory commission reported its findings and made its recommendations to the Governor and Joint Committee on Health Care in October of 1992. It is hoped that these recommendations will be useful in furthering the legislation's goal of improving quality in health care.

Hospital Profiles

In response to the competitive market environment, hospitals have changed the way they do business. The intent of this type of information is to broaden public understanding of hospitals which play a major role in the changing health care system. Hospital profiles provide needed data on the distribution of health care resources in Massachusetts. Financial indicators and utilization figures are also included to provide a basis for cross-hospital comparisons. This kind of basic information will enable purchasers, providers, and consumers to make wise health care decisions by comparing available hospital resources in the state. It also will enable purchasers and providers of health care to start a dialogue or negotiation at a more informed level. This information is not provided by anyone else in the state, and is essential for informed decision-making in a competitive market.

Summary of Policy Analyses and Data Dissemination

The Rate Setting Commission has a full data analysis and dissemination agenda related to the provisions laid out in Chapter 495. Using current and expanded data resources, the Commission produces reports to inform purchasers, aid providers, and educate legislators about the implementation and subsequent effects of this law.

Policy Analyses and Data Dissemination

The Commission is charged with the responsibility to:

1) monitor the competitive marketplace—hospital costs and revenues, financial condition, services provision and industry structure;

2) inform the competitive marketplace on hospital costs and services;

3) study the costs of—and access to—health insurance;

4) monitor services for the uninsured;

5) research quality and outcomes measures;

6) study quality improvement principles in the health care industry; and

7) publish a hospital profiles reference guide.

Calculating Compliance Liability

During the current fiscal year, the Massachusetts Rate Setting Commission will complete its obligations under the acute hospital payment system which expired in October, 1991—Chapter 23 of the Acts of 1988 (Chapter 23). Chapter 495 of the Acts of 1991 (Chapter 495), the successor law, directed the Commission to complete all pending Maximum Allowable Cost (MAC) audits and reviews and to calculate compliance liability under the revenue provisions of the law. If the Commission finds that a hospital over-generated revenue during the years that Chapter 23 was in effect, then the hospital must pay a portion of the excess revenue into the Uncompensated Care Pool. The Commission developed regulations which specify that portion of the over-generation which must be paid by the hospital. The regulation permits a hospital to amortize payment over a five-year period. In cases of severe financial hardship, a hospital may receive a five year deferral period in addition to its five-year payment period.

Determining Final Settlements for Blue Cross of Massachusetts

The Massachusetts Blue Cross "master contract" also calls for a wrap-up of Chapter 23 issues, since Blue Cross of Massachusetts has an obligation to make final settlements with hospitals based on the results of Commission reviews. Moreover, payments under upcoming contracts will be derived from a hospital's last approved "basis of payment."

Wrapping-up Chapter 23

Finalizing Chapter 23 is a major undertaking. Most Units of the Commission's Bureau of Hospitals take part in this project. Twenty (20) members of the acute care hospital staff are involved directly. Assisting them are three (3) members of the Information Processing Unit, one (1) clinical advisor, and five (5) administrative support staff. Commission lawyers provide legal support, and the Bureau of Systems Development provides case-mix tapes. The Commission is dependent on documentation from the Massachusetts Department of Medical Security (DMS) which is responsible for auditing bad debt/free care expenses.

The Bureau of Hospitals has established a target date of June 30, 1994 for completion of the Chapter 23 wrap-up.

Introduction

Historically, the Bureau of Long-Term Care Facilities of the Massachusetts Rate Setting Commission has been responsible for establishing rates of payment for Medicaid-funded residents in nursing homes, rest homes, and Intermediate Care Facilities for the Mentally Retarded (ICF-MRs). During Fiscal Year 1993, the rate methodologies for each of these three categories of service were in transition. The nursing home industry, numbering 550 providers, experienced an aggressive "clean-up" of outstanding rate issues. The rest home industry, numbering 130 providers, faced the impact of an on-going decline in utilization. And, the 75 ICF-MRs were transferred on a staggered basis from the Commission's jurisdiction to a negotiated-rate system.

Nursing Homes

Resolution of outstanding issues for reimbursement periods prior to the 1994 rate year was a great accomplishment for the Bureau. This required the promulgation of "final" rates for 1989 and 1990, the last years for which some or all of the industry was reimbursed under a retrospective system, and the certification of desk-audited prospective rates for 1990 through 1993. This monumental task was completed in October of 1993. At the same time, the Bureau already was working on refinements to the prospective payment system.

Wrapping up the Retrospective Payment System

The Commission generated 550 "preliminary" final rates of reimbursement in calendar year 1990 for the 1989 rate year using the 1989 cost report data. These "preliminary" final rates allowed the Division of Medical Assistance (Medicaid) to meet most of its outstanding obligation to the nursing home industry for allowable 1989 expenses. During Fiscal Year 1993, the Bureau took up the task of incorporating desk-audit adjustments to set the final retrospective rates for the 1989 rate year. This process required staff to reconcile the 1989 "preliminary" final rates that were paid to providers during 1990 with the actual final rates calculated after desk audit adjustments. It was critical to conduct this review in a careful and thorough manner, as 1989 audited cost data was used to set rates effective July, 1, 1991, January 1, 1992 and January 1, 1993.

Since the prospective case-mix reimbursement system was implemented in 1990 for approximately 190 homes, the Commission was required to set final 1990 retrospective rates for the remaining 360 nursing homes using the desk-audited 1990 cost report data. Completing this "clean-up" of outstanding rate issues increased the Commission's ability to set prospective rates for 1994 prior to the start of the rate year.

Implementing the Prospective Case-Mix Payment System

The Commission has devoted considerable resources to the perfection and simplification of the prospective payment methodology. This system was implemented on an experimental basis in 1989 for 17 homes and expanded to 190 homes in 1990. The state-wide implementation was completed in 1991. The Commission also has made various modifications, over time, as more has been learned about the impact of the new system on the Commonwealth and the industry. The overall objective has been to make the system less cumbersome. It is important to note that adjustments made to the rates, while administratively burdensome, have tended to favor the provider community. The Commission is unaware of any negative impact on access or quality.

It is the goal of the Commission to produce a prospective reimbursement system that has the following characteristics:

- ***Full prospectivity.*** Nursing home rates should be set prior to the beginning of a rate year and should not change. Until recently, prospective rates were set before a desk audit was completed, requiring that they be re-set upon completion of the desk audit. Currently, the system is able to establish desk-audited rates prior to the beginning of the rate year.

- ***Predictability.*** The Commission is working continually to expedite system design changes in order to afford both the state and the provider community the opportunity to plan their respective financial positions adequately before the rate year begins.

- ***Simplicity.*** The Commission's goal is to make the reimbursement system understandable to each-and-every nursing home administrator. When systems are too complex, providers may choose to delegate the responsibility for mastering the new system to outside consultants. By educating providers on the new system, they in turn can provide care in an effective and economic fashion.

- ***Access and Quality.*** The Division of Medical Assistance is under an obligation to ensure that quality services are accessible to its Medicaid-funded clients. The new prospective system is successful in this regard. The case-mix component of the system ensures that providers receive reimbursement according to the acuity needs of their residents. If a resident requires a high level of service, the rate is correspondingly higher. This feature is particularly effective in placing residents who may otherwise occupy a hospital bed beyond the necessary length of stay.

- ***Economic Feasibility.*** The Commission is committed to designing a system that is balanced between what is desired and what is realistic. Commission staff continually work with the provider community to ensure that the nursing home reimbursement system *is* well-balanced.

Rest Homes

Rest homes are reimbursed on a single-rate prospective payment system. The number of rest home service providers in Massachusetts has declined in recent years. The Rate Setting Commission is engaged in a broad examination of the various market forces impacting this industry. The Executive branch is currently investigating the possibility of deregulating the rest home reimbursement system. The Commission will contribute to the analysis of this option and expects to continue to have a valuable role in shaping the rest home marketplace.

ICF-MRs

Intermediate Care Facilities for the Mentally Retarded (ICF-MRs) care for clients of the Massachusetts Department of Mental Retardation (DMR). On July 1, 1993, DMR assumed full responsibility of the rate-setting function for these facilities. Since there are only 75 providers, serving between seven and fifteen clients each, DMR feels that negotiating separately with each provider results in a better link between quality and payment. The Commission assisted with this transition and continues to provide technical support to DMR as needed.

Activities and Accomplishments

The Bureau of Long-Term Care Facilities had a number of major projects during fiscal year 1993 and continuing into fiscal year 1994. Significant accomplishments include:

1) *closing out the back-log of final rates under the retrospective reimbursement system. This major undertaking has allowed the bureau to focus on enhancing the prospective reimbursement system;*

2) *implementing a streamlined nursing home regulation for 1994 which made the reimbursement system fully prospective;*

3) *enhancing the bureau's computer capabilities with new software and appropriate training, enabling more timely rate calculations and report production; and*

4) *providing oversight of the cost of nursing home personnel through the use of a quarterly wage survey.*

Introduction

The Bureau of Ambulatory Care has primary responsibility for a broad array of health care services, including individual medical and surgical services, in-home and elderly services, community and mental health facilities, early intervention and substance abuse treatment programs and ancillary goods and services. The Bureau's work is directed toward services which either complement or serve as alternatives to more costly inpatient hospital or nursing home care. The majority of preventive and primary health care is provided in ambulatory settings.

These areas represent over 30,000 individual care-givers, in over 22,192 provider organizations. Ambulatory care services account for approximately 25% (over $700,000,000 in Fiscal Year 1992) of governmental health and social service expenditures. The Bureau of Ambulatory Care collects financial and statistical data useful in the development and implementation of public health care policy. This fiscal year, the Bureau expects to establish reimbursements for the public purchase of approximately 15,500 individual health care services.

Focus and Objectives

The Bureau's work focuses on an environment where far-reaching changes—occurring in hospital reimbursement, among the ever-growing elderly population, the severely or terminally ill, and the uninsured and under-insured—encourage greater utilization of ambulatory care services. As a result, the Bureau's work continues to grow in complexity in response to the changing needs of the health care community.

The primary objective of the Bureau in this environment is to establish reimbursement methodologies which encourage cost containment while ensuring equal access to quality care. The Bureau also seeks to provide incentives that encourage the expansion of services which state policy supports as a priority objective. An example of this is the newly established class rate structure for home health services which became effective in January, 1994.

The Bureau currently is involved in a number of projects designed to streamline provider reporting and improve the quality of reported data. One such effort, currently under way, is an investigation into the use of the Division of Purchased Services' Uniform Financial Report—in order to end duplicative reporting. Automation of the community health center cost report may serve as a prototype for the electronic filing of cost and statistical data. A current project involves an analysis of home health agencies and features electronic report filing as an option.

The bureau also is involved in the preparation of an automated "rate library" which will permit insurance companies, claims processors, benefit managers, providers and health policy makers to electronically access up-to-the-minute changes in reimbursement schedules.

Health Policy Initiatives

Analysis of Preventable Hospitalization in Massachusetts

The use of preventable hospitalization as an evaluation tool has tremendous potential to reduce health expenditures by avoiding costly, intensive, hospital-based procedures. This relatively new approach looks at bad outcomes, or preventable hospitalizations, as an indication of inadequacies in preventive or primary care. A small area analysis of preventable hospitalization for primary care manageable conditions has pinpointed geographic areas and diagnoses which can be targeted for more aggressive primary care and outreach.

Medicaid and community health centers are beginning to look at these data in an effort to improve access to high quality primary care. A report targeted to these users was released by the Rate Setting Commission in January 1994. Great interest in this project among policy-makers and providers has spurred several spin-off projects:

- *Analysis of Medicaid Recipients with Primary Manageable Conditions.* This study will show which patients reach the point where they require preventable hospitalization and which are treated successfully in non-hospital settings. This collaborative effort with the Division of Medical Assistance will examine the Medicaid data base for fiscal years 1991 and 1992. Use of this comprehensive data base also will enable examination of the relationship between outpatient and inpatient care.

- *Demographic Analysis of Medicaid Recipients with Asthma.* Another collaborative study with the Division of Medical Assistance will closely examine asthma patients to determine how demographic and treatment differences are associated with preventable hospitalizations, high costs, and other adverse health outcomes. Asthma was chosen for three reasons: 1) it is the focus of a medicaid quality improvement project; 2) previous intervention studies have had great success with reducing asthma hospitalizations; and 3) our data show that 23.6 percent of the total Medicaid preventable hospitalization cases were for asthma. In 1989 and 1990, we estimate that preventable asthma hospitalizations cost Medicaid approximately $11.9 million.

Profiles of People with HIV/AIDS in Massachusetts: Predictors of Utilization, Cost and Outcomes for Medicaid Recipients

The purpose of this collaborative work with Medicaid is to identify specific costs and associated service utilization for the health and medical care of people with AIDS and HIV-related

conditions enrolled in the Massachusetts Medicaid program. One goal is to determine the provider types, services, and claims associated with HIV infection among people in different stages post HIV diagnosis, and to examine changes over time. Comparisons will be made within three pediatric age groups and among women and men. In addition, this project seeks to generate information for the development of comprehensive models of AIDS and HIV-related care.

Medicaid claims data include information on diagnostic conditions, service use, provider types, and associated costs in both inpatient and outpatient settings. Detection of trends in utilization and costs requires an analysis of provider mix, service type, and associated costs in the last year of life. Further examination will provide service utilization trends, including changes and shifts (inpatient versus outpatient versus home based) over time. The exploration of race age and location will provide necessary patient specific information for targeted interventions. The comprehensive and longitudinal nature of the Medicaid AIDS research data base will allow us to evaluate patterns of care and assess impacts of care on patient survival and resource use.

Coupled with a concerted effort to disseminate data to all concerned parties, these projects are designed not only to encourage a reduction of the costs of service, but to help provide the information necessary for providers, as consumers of goods and services, to make informed purchasing decisions, thereby reducing the cost of service.

Fiscal Year 1993 Accomplishments

Health Care Costs in Massachusetts

The Massachusetts Rate Setting Commission completed its first major publication under its expanded information mandate—*Health Care Costs in Massachusetts*—in December 1992. The report examines three substantive areas: the reasons for increasing health insurance premiums, the variation in unit costs in Massachusetts hospitals and geographic differences in hospital utilization.

The purpose of the report was to introduce information tools that users could employ in seeking opportunities for improvement in these areas, either as providers of care or as purchasers of services and insurance. Rather than create a confrontational atmosphere by ranking providers and services in a "shoppers' guide", the report recognizes the existence of multiple influences on costs and utilization and seeks to promote an environment of cooperation among various actors in identifying and controlling the causes of excessive variation.

Dialogue with Information Users

The primary goal of the Commission's health care information products is that they be relevant and useful to those making decisions in the health care market, and that they be used to effect change that leads to a more cost effective system. Toward this end, the Commission established a dialogue with an extensive network of representatives of hospitals, physicians, insurers, Health Maintenance Organizations (HMOs), employers and others. This dialogue serves a dual purpose: to educate users about the information in *Health Care Costs in Massachusetts* and the other data collected by the Commission, and to learn from these users what further information would be most useful in supporting their health care decisions. This process of feedback is perhaps as important a feature of the information agenda as the final products themselves.

Planning the Agenda

Internally, the Commission undertook an intensive planning process to set the agenda of information projects for the coming year. Addressing its policy monitoring mandate, a process to frame a series of specific policy questions and consider the data and analyses required to answer them, resulted in a group of discrete policy monitoring projects. In addition, responses to *Health Care Costs in Massachusetts* and other feedback from users in the health care market provided input into the specification of the "second generation" of market and management information for purchasers and providers.

Fiscal Year 1994 Activities

The Commission has built on its accomplishments in the information arena during Fiscal Year 1993 with a number of projects in Fiscal Year 1994. The Commission collects, analyzes and distributes health care information to fulfill three basic objectives:

- *Market information for purchasers.* The Commission provides information to the market aimed at making competition effective. To this end, Commission staff are working with purchasers (e.g., employers, HMOs, insurers) and health care providers to develop information products that facilitate contract negotiations and performance monitoring, and inform behavior that results in a more efficient and effective delivery system.

- *Management information for providers.* Information on the industry provided by the Commission serves as a critical management tool for providers. It can also be shared with state and private purchasers to assist in making prudent health care spending decisions.

- *Policy monitoring.* The Commission is monitoring the state of the health care system under the policies established by Chapter 495—the hospital financing law. The results of these studies will inform further policy action by the administration and legislature.

Resources

To complete these projects and ensure their continuing relevance to multiple users, Commission staff perform these functions:

- *Data Collection.* This is a continuation and an expansion of an existing function. The Commission collects important and useful data from hospitals and other health care providers. Substantial time is devoted to learning how best to apply these data to useful information products.

- *Research and analysis.* The Commission undertakes research and analysis for the purpose of policy evaluation. We also are developing and testing tools to measure clinical quality and outcomes, for example.

- *Education and technical assistance.* In additional to providing information, the Commission continues to educate purchasers and providers on the use and application of information.

◆ *Dissemination and reporting.* The Commission continues to publish official reports and provides access to data sets. Information products are reviewed and revised through regular communication with users.

Information project managers meet regularly and work closely with the Commission's Office of Communications to ensure that information is published and disseminated in a form useful to its target audience, and in an accurate and timely manner.

Commission staff in the three line bureaus—Bureau of Hospitals, Bureau of Ambulatory Care and Bureau of Long-Term Care Facilities—possess extensive analytical expertise. Information project managers and staff are culled from these bureaus and as the information mission takes on greater importance for the Commission, more and more staff time is devoted to these important projects.

Finally, the Commission has found it necessary in limited circumstances to contract with outside consultants for technical assistance. An example of such contracting includes bringing aboard expert assistance in development measures and evaluation methodologies.

Activities and Objectives

The Office of Research and Management Initiatives is responsible for a wide-range of research and management support activities at the Massachusetts Rate Setting Commission (MRSC). These responsibilities fall into three categories:

- ***Research.*** Research activities involve regular review and analysis of health services literature to identify valuable research methods and results which serve to promote quality improvement and cost-effectiveness in the health care system.

- ***Staff Development.*** Efforts in this area focus on the identification and organization of projects which enhance the management and analytical skills of agency staff. The office selects and arranges for health policy speakers to give talks at the Commission highlighting recent changes and innovations in the health care system; plans in-house courses on topics such as health economics, health insurance, statistics and quality improvement methods; and is improving the MRSC resource library holdings, arrangement of materials and access.

- ***Management Initiatives.*** The Office supports all quality improvement activities at the Commission. The MRSC applies quality improvement methods to its own work in order to increase efficiency, reduce duplication of effort and better meet the agency goal of fostering quality improvement and efficiency in the delivery of health care services in Massachusetts. To this end, the Office reviews management research literature (including quality improvement, statistical process control and organization theory) and consults with experts in the field to identify and develop applications of methods and results which have the potential to improve staff effectiveness in meeting the challenge of fostering a cost-effective health care system.

In Fiscal Year 1993, the Commission sponsored two quality improvement pilot projects. One, sponsored jointly with the Medicaid program, focussed on reducing the cycle time for processing physician rates. The other was aimed at reducing the time needed to release hospital discharge data. Both projects made substantial progress, including recommendations for improving management methods at both agencies, and helped those participating to learn quality improvement techniques.

Introduction

The Commission's legal staff performs three main functions: 1) litigation of administrative appeals filed by providers and support to the Attorney General on litigation of court cases involving the Commission, 2) analysis of and response to proposed legislation, and 3) provision of legal advice to Commissioners and staff concerning development and application of regulations and policy positions as well as matters arising in connection with the Commission's expanded information agenda.

Litigation

The legal staff attorneys represent the Commission in administrative appeals filed with the Division of Administrative Law Appeals (DALA), an agency within the Executive Office of Administration and Finance. Pursuant to M.G.L. c.6A, s.36, an individual provider who is aggrieved by the rate the Commission sets may file an appeal claiming that the rate does not meet the statutory standard that rates be fair, reasonable and adequate. These appeals are governed by the Formal Rules section of DALA's Standard Adjudicatory Rules of Practice and Procedure, which means that if the case goes to trial there is a formal adjudicatory hearing. Currently, there are over two thousand administrative appeals outstanding.

The legal staff attorneys also assist the Attorney General's office in litigating court cases involving the Commission. Currently, there are over one hundred court cases outstanding. Some of these cases are petitions for review of DALA decisions in administrative appeals. Most such petitions for review are filed by providers. A few are filed by the Commission because, unlike most agencies, the Commission does not have the final decision on its own appeals. It cannot refuse to accept a decision by DALA; it can only file a petition for review. In most instances, the Commission files such a petition for review only where it believes the DALA decision goes beyond the scope of DALA's jurisdiction in an administrative appeal.

Another group of court cases are challenges to the validity of regulations of general applicability. These cases are filed pursuant to M.G.L. c.30A, s.7, usually by a group of providers or by the industry association representing all the providers. The question in these cases is whether the regulation has a rational basis.

Another group of court cases involves Blue Cross litigation. Under M.G.L. c.176A, appeals of Commission action on Blue Cross contracts and audit adjustments, and on most exception requests under the prior hospital system, go directly to the Supreme Judicial Court.

In addition, Commission attorneys participate in various hearings concerning bankruptcies and patient protection receiverships. Although the Commission usually is not a party to these cases, there are often rate matters to be resolved or to be explained to the court.

Legislation

The Legal Bureau is the site of the Commission's legislative work. Legal staff analyzes and summarizes current legislation, drafts the Commission's testimony before legislative committees, communicates with the legislature, and drafts and redrafts proposed legislation. The legislature works on a calendar year, so our activities during a particular fiscal year encompass the end of one legislative session and the beginning of the next.

In November and December, legal staff work with the Commissioners and bureaus to determine if there is any legislation the Commission wishes to file in the coming legislative session. Staff then drafts such legislation, and summarizes and explains the rationale to the Executive Office of Health and Human Services (EOHHS) which determines whether or not the proposal will be included in the Administration's legislative package.

Once the House and Senate bills are issued in the new legislative session, legal staff determine which of the approximately 7000 bills involve the Commission's jurisdiction, activities or concern issues the Commission wishes to monitor. These bills are tracked and analyzed for their impact on the Commission and on the health care system as a whole. The Commissioners often appear at or submit written testimony for legislative committee hearings, especially hearings of the Health Care Committee or Human Services Committee. Legal staff draft this testimony and also serve as a resource for committee staff in explaining the implications of bills and how the health care system functions.

During budget debates, debates on particular bills, and throughout the legislative session, legal staff continue to foster communication between the legislature and the Commission through comments on the impact of particular legislative initiatives, education on the health care reimbursement system in general, explanation of Commission regulations and other initiatives, and information on specific constituent inquiries.

Advising

The legal staff also provides legal advice to Commissioners and staff concerning both the Commission's regulatory functions and its expanded information function.

The Commission's rate-setting methodologies and data collection requirements are set forth in over 40 regulations. Most of these regulations govern rates for non-institutional services and must be updated every two years. The regulations for hospitals and long-term care facilities, which generally are more complicated, must be updated yearly. Due to changes in federal and state law and to the volatile nature of the health care markets, the hospital regulations have been amended several times in addition to the regular updates. Promulgation of new regulations is a lengthy and technical process which must comply with the State Administrative Procedure Act and Executive

Order #145 (notice to agencies representing cities and towns), and for Medicaid rates, with relevant provisions of federal regulations.

Because the regulations establish the details of the reimbursement system or data collection, they must be drafted carefully to ensure that they accurately and unambiguously set forth the Commission's policies. Legal staff also ensure that relevant substantive state and federal requirements are met and that the Commission's regulatory provisions do not conflict with those of other agencies. Legal staff also identify regulation provisions which should be added, amended or clarified to avoid or withstand legal challenge.

Legal staff provide advice concerning the day to day interpretation and application of the regulations. This can occur both with respect to a particular provider's rate or with respect to an overall policy initiative. In doing so, legal staff often coordinates with other state human service agencies or with the regional office of the federal Health Care Financing Administration, or with the Attorney General's office if the issue may produce litigation.

As the Commission develops its research and information role, legal staff assist and advise bureau staff concerning issues such as data confidentiality, structuring of agreements to share data, and provider corporate organization. Legal staff also keep bureau staff informed of new state or federal laws affecting health care, and advise concerning various legal issues which arise in the research projects.

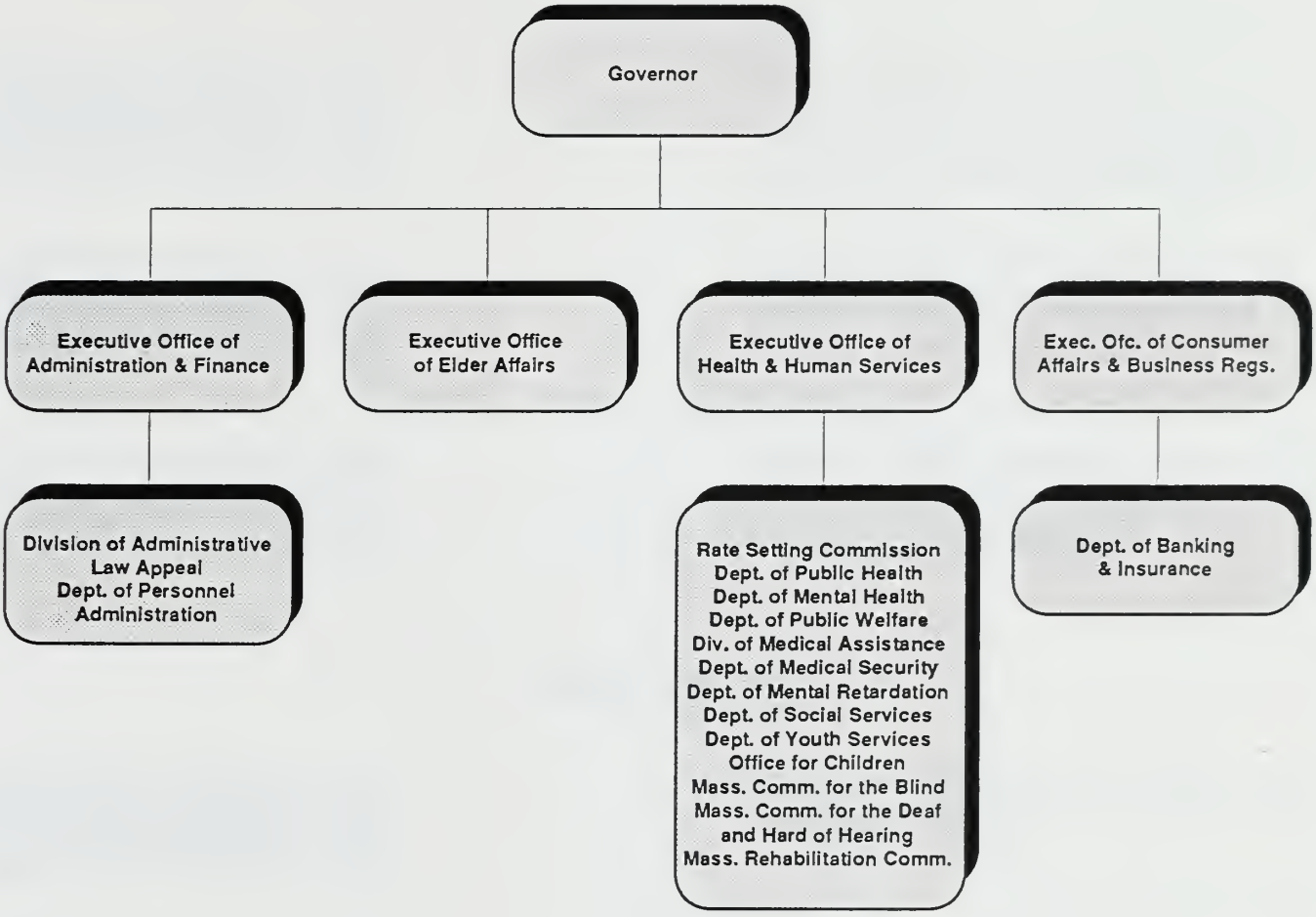
Responsibilities and Oversight

The acute care hospital payment law, Chapter 495, established a seven-member panel, called the Hospital Payment Advisory Commission (HospPAC), to examine and evaluate four specific aspects of the hospital financing system:

- the implementation of disproportionate share rates by the Rate Setting Commission;
- rates of payment in Medicaid contracts;
- adherence by payers and providers to recognized fair market contracting standards and the proposal of additional standards when appropriate; and
- an assessment of the Determination of Need (DoN) program, including consideration of the impact, if any, on the competitive position of health care facilities located near state borders.

HospPAC is an advisory body with an agenda limited by statute. Unlike an independent agency, it has no regulatory or enforcement powers. Like other advisory boards, it may hire an executive director and qualified staff whose salaries are funded by an assessment on acute hospitals. Members serving on HospPAC must be proficient in certain fields. One must be an attorney knowledgeable in anti-trust and contract law. Another must be familiar with hospital financial management. The Governor must draw the remaining members from a list of recognized experts in health economics, general management and economics, public health policy, or medical science and practice.

The Massachusetts Rate Setting Commission has an important role to play with respect to this entity. To perform its analyses, HospPAC is completely dependent on information provided to it by the Commission and several of its sister agencies: the Massachusetts Departments of Public Health, Public Welfare, and Medical Security, and the Division of Insurance. To collect additional data, it must do so through the Commission or through an appropriate agency with data collection authority. The availability of accurate and consistent data is critical to the success of the panel, and the Commission is poised to contribute information from its extensive data base.



Please note: this chart does not show the entire Executive Branch; agencies with whom the Commission works are represented above.

Notification

35 Days Prior	Notify Executive Office of Community Development (EOCD) and Mass. Municipal Association
30 Days Prior	Notify MRSC Advisory Council of the Rate Setting Commission's Proposed Course of Action
21 Days Prior	Publish Public Hearing Date in Two Daily Newspapers and the Massachusetts Register

Public Hearing

10 Days After	Records Held Open for Public and Interested Parties
30 Days After	Records Held Open for Advisory Council

Any Time After 30 Days
the Commission May Act on a Proposed Regulation

Fiscal Year 1993 Public Hearings

Date	*Regulation*	*Subject*
07/10/92	114.2 CMR 3.00	Prospective Rate Determination for Intermediate Care Facilities for the Mentally Retarded (ICF-MRs)
07/10/92	114.1 CMR 28.00	Systems for Review and Approval of Non-Acute Hospital Charges, Publicly Assisted Rates of Payment, and Industrial Accident Rates of Payment
07/20/02	114.3 CMR 16.00	Surgery and Related Anesthesia Care
07/20/92	114.3 CMR 17.00	Medical and Related Anesthesia Care
07/20/92	114.3 CMR 18.00	Radiology
07/20/92	114.5 CMR 8.00	Day Habilitation Program Services
07/20/92	114.3 CMR 12.00	Family Planning Services
07/20/92	114.3 CMR 13.00	Rates for Freestanding Clinics Providing Abortion and Sterilization Services
07/20/92	114.3 CMR 4.00	Rates for Community Health Centers
08/24/92	114.3 CMR 39.00	Rehabilitation Clinic Services, Audio-Logical Services; Restorative Services
08/24/92	114.3 CMR 14.00	Dental Services
09/01/92	114.3 CMR 15.00	Vision Care Services and Opthalmic Materials
09/01/92	114.1 CMR 36.00	Regulations Governing Acute Care Hospital Charges
09/23/92	114.3 CMR 26.00	Podiatric Care
10/19/92	114.1 CMR 28.00	Systems for Review and Approval of Non-Acute Hospital Charges, Publicly Assisted Rates of Payment, and Industrial Accident Rates of Payment
10/27/92	114.1 CMR 36.00	Regulations Governing Acute Care Hospital Charges
11/24/92	114.1 CMR 28.00	Systems for Review and Approval of Non-Acute Hospital Charges, Publicly Assisted Rates of Payment, and Industrial Accident Rates of Payment
11/24/92	114.1 CMR 28.00	Systems for Review and Approval of Non-Acute Hospital Charges, Publicly Assisted Rates of Payment, and Industrial Accident Rates of Payment

Date	*Regulation*	*Subject*
12/08/92	114.1 CMR 36.00	Regulations Governing Acute Care Hospital Charges
11/23/92	114.1 CMR 36.00	Regulations Governing Acute Care Hospital
01/09/93	114.2 CMR 4.00	Rates of Payment to Resident Care Facilities
01/08/93	114.5 CMR 7.00	Rates for Early Intervention Program Services
01/22/93	114.1 CMR 28.00	Systems for Review and Approval of Non-Acute Hospital Charges Publicly Assisted Rates of Payment, and Industrial Accident Rates of Payment
01/26/93	114.2 CMR 5.00	Prospective Rates of Payment to Long-TermCare Facilities
02/05/93	114.3 CMR 37.00	Chronic Maintenance Dialysis Treatments and Home Dialysis Supplies
02/05/93	114.1 CMR 36.00	Regulations Governing Acute Care Hospital Charges Under St. 1991 c. 495
03/02/93	114.3 CMR 12.00	Family Planning Services
03/15/93	114.3 CMR 27.00	Ambulance Services
03/15/93	114.3 CMR 28.00	Chiropractic Services
03/24/93	114.5 CMR 6.00	Rates for Certain Substance Abuse Programs
04/09/93	114.3 CMR 43.00	Hospice Services
05/26/93	114.1 CMR 36.00	Regulations Governing Acute Care Hospital Charges Under St. 1991 c.495
06/02/93	114.1 CMR 36.00	Regulations Governing Acute Care Hospital Charges Under St. 1991 c.495
06/24/93	114.3 CMR 4.00	Rates for Community Health Centers
06/30/93	114.1 CMR 17.00	Requirement for the Submission of HospitalCase Mix and Charge Data
06/30/93	DIF-21 BLUE CROSS	Participating Diagnostic Imaging Service Payment Agreement
06/30/93	114.3 CMR 40.00	Rates for Services Under Worker's Compensation Act

Regulations Amended and Promulgated During Fiscal Year 93

Bureau of Hospitals

Regulation	*Title*	*Approved*
114.1 CMR 33.00	Review and Approval of Acute Hospital Charges and Determination of Rates of Payment by Third Party Payers Other Than Medicare	07/09/92
114.1 CMR 36.00	Regulations Governing Acute Care Hospital Charges Under St. 1991 C. 495	07/09/92
114.1 CMR 28.00	Systems for Review and Approval on Non-Acute Hospital Charges, Publicly Assisted Rates ofPayment and Industrial Accident Rates ofPayment	09/10/92
114.1 CMR 28.00	Systems for Review and Approval on Non-Acute Hospital Charges, Publicly Assisted Rates of Payment and Industrial Accident Rates of Payment	09/18/92
114.1 CMR 36.00	Regulations Governing Acute Care Hospital Charges Under St. 1991 C. 495	10/01/92
114.1 CMR 33.00	Review and Approval of Acute Hospital Charges and Determination of Rates of Payment by Third Party Payers Other Than Medicare	10/02/92
114.1 CMR 36.00	Regulations Governing Acute Care Hospital Charges Under St. 1991 C. 495 (public hearing 06/23/92)	12/23/92
114.1 CMR 36.00	Regulations Governing Acute Care Hospital Charges Under St. 1991 C. 495 (pubic hearing 10/27/92)	12/23/92
114.1 CMR 28.00	Systems for Review and Approval of Non-Acute Hospital Charges, Publicly Assisted Rates of Payment and Industrial Accident Rates of Payment	01/14/93
114.1 CMR 28.00	Systems for Review and Approval of Non-Acute Hospital Charges, Publicly Assisted Rates of Payment and Industrial Accident Rates of Payment	02/25/93
114.1 CMR 36.00	Regulations Governing Acute Care Hospital Charges Under St. 1991 C. 495	02/25/93

114.1 CMR 28.00	Systems for Review and Approval of Non-Acute Hospital Charges, Publicly Assisted Rates of Payment and Industrial Accident Rates of Payment	04/16/93
114.1 CMR 36.00	Regulations Governing Acute Care Hospital Charges Under St. 1991 C. 495	04/16/93

Bureau of Long-Term Care Facilities

Regulation	*Title*	*Approved*
114.2 CMR 3.00	Prospective Rate Determination for Intermediate Care Facilities for the Mentally Retarded (ICF-MR)	09/13/92
114.2 CMR 4.00	Rates of Payment to Resident Care Facilities	02/11/93
114.2 CMR 5.00	Prospective Rates of Payment to Long-Term Care Facilities	04/01/93

Bureau of Ambulatory Care

Regulation	*Title*	*Approved*
114.3 CMR 26.00	Podiatric Care	10/29/92
114.3 CMR 37.00	Chronic Maintenance Dialysis Treatments and Home Dialysis Supplies	03/11/93
114.5 CMR 7.00	Rates for Early Intervention	03/11/93
114.3 CMR 3.00	Home Health Agency Services	04/22/93
114.3 CMR 12.00	Family Planning Services	04/22/93
114.3 CMR 27.00	Ambulance Services	04/22/93
114.3 CMR 28.00	Chiropractic Services	04/22/93
114.5 CMR 6.00	Rates for Certain Substance Abuse Programs	05/06/93
114.3 CMR 43.00	Hospice Services	05/20/93
114.3 CMR 40.00	Rates for Services Under Worker's Compensation Act	06/30/93

Fiscal Year 1993 Advisory Rulings

Ruling	*Petitioner*	*Subject*
AR-1-93	Gerald J. Billow Posternak, Blankstein & Lund	Related Party Interest
AR-2-93	Jan S. Adams Healthcare and Non-Profit Group	DoN Waiver
AR-3-93	Douglas Feibelkorn Landa & Altsher	Self Insurance
AR-4-93	Susan A. Flanagen	Contributions

◆ Three Members Appointed by the Governor

Chairman (must have administrative experience and an advanced degree in business administration, public administration, or law)

Certified Public Accountant

Medical Economist

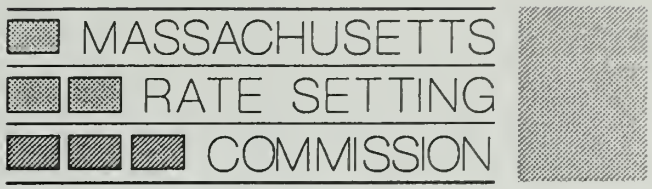
◆ No more than Two Members May Be from the Same Political Party

◆ Each Member Is Appointed for Three Years with Staggered Appointments

Current Appointments

Paula R. Griswold, Chairman
Louis I. Freedman, Medical Economist
Margaret Long Randle, Certified Public Accountant

Jonelle L. Soelling, Certified Public Accountant
(Commissioner through Fiscal Year 1993)



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